		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027342

Facility Name: CANTERBURY MANOR NURSING CENTER

Address: 718 MARKET (Number) WATERLOO (City) 62298 (Zip Code)

County: MONROE

Telephone Number: (618) 939-3650 **Fax #** (618) 939-9488

IDPA ID Number: 371119687001

Date of Initial License for Current Owners: 03/01/70

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: ROGER W. BAGLEY **Telephone Number:** (618) 549-8331
JAMESTOWN MANAGEMENT CORP

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) ROGER W. BAGLEY
(Title) CONTROLLER

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	20	Skilled (SNF)	20	7,320	1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,764	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	74	TOTALS	74	27,084	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF		441	605	1,046	8
9	SNF/PED					9
10	ICF	13,593	10,181		23,774	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,593	10,622	605	24,820	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.64%

D. How many bed-hold days during this year were paid by Public Aid?
127 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 03/01/70

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 20 and days of care provided 605

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTI # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	100,262	6,079	5,313	111,654		111,654		111,654			1
2	Food Purchase		66,817		66,817	5,939	72,756	(931)	71,825			2
3	Housekeeping	52,304	10,159		62,463	362	62,825		62,825			3
4	Laundry	42,585	9,529	30	52,144		52,144		52,144			4
5	Heat and Other Utilities			56,192	56,192	450	56,642		56,642			5
6	Maintenance	22,088	20,204	22,238	64,530		64,530		64,530			6
7	Other (specify):*											7
8	**TOTAL General Services**	217,239	112,788	83,773	413,800	6,751	420,551	(931)	419,620			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	690,410	24,369	20,339	735,118	(5,186)	729,932		729,932			10
10a	Therapy	17,297		5,547	22,844		22,844		22,844			10a
11	Activities	34,625	3,732	2,160	40,517	(1,774)	38,743		38,743			11
12	Social Services	27,333		2,160	29,493		29,493		29,493			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	769,665	28,101	30,206	827,972	(6,960)	821,012		821,012			16
	C. General Administration											
17	Administrative	54,173			54,173	60,276	114,449		114,449			17
18	Directors Fees											18
19	Professional Services			199,830	199,830	(108,479)	91,351	(82,669)	8,682			19
20	Dues, Fees, Subscriptions & Promotions			7,551	7,551	155	7,706	(3,053)	4,653			20
21	Clerical & General Office Expenses	19,002	7,072	6,483	32,557	28,722	61,279	(606)	60,673			21
22	Employee Benefits & Payroll Taxes			157,284	157,284	8,772	166,056	(2,821)	163,235			22
23	Inservice Training & Education			607	607		607		607			23
24	Travel and Seminar			2,514	2,514	205	2,719		2,719			24
25	Other Admin. Staff Transportation					1,667	1,667		1,667			25
26	Insurance-Prop.Liab.Malpractice			8,142	8,142	1,075	9,217		9,217			26
27	Other (specify):*											27
28	**TOTAL General Administration**	73,175	7,072	382,411	462,658	(7,607)	455,051	(89,149)	365,902			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,060,079	147,961	496,390	1,704,430	(7,816)	1,696,614	(90,080)	1,606,534			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER #0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			38,802	38,802	2,800	41,602	12,037	53,639			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							15,009	15,009			33
34	Rent-Facility & Grounds			311,400	311,400	5,016	316,416	(311,400)	5,016			34
35	Rent-Equipment & Vehicles			235	235		235		235			35
36	Other (specify):*											36
37	TOTAL Ownership			350,437	350,437	7,816	358,253	(284,354)	73,899			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,994	53,320	66,314		66,314		66,314			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			40,626	40,626		40,626		40,626			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		12,994	93,946	106,940		106,940		106,940			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,060,079	160,955	940,773	2,161,807		2,161,807	(374,434)	1,787,373			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(636)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	664	30		9
10	Interest and Other Investment Income	(28,557)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(295)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(54)	21		18
19	Entertainment				19
20	Contributions	(552)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,490)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(563)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(2,821)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (35,304)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(339,130)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (339,130)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (374,434)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(931)	0	0	0	0	0	0	0	0	0	0	(931)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(931)	0	0	0	0	0	0	0	0	0	0	(931)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(82,669)	0	0	0	0	0	0	0	0	0	(82,669)	19
20	Fees, Subscriptions & Promotions	(3,053)	0	0	0	0	0	0	0	0	0	0	(3,053)	20
21	Clerical & General Office Expenses	(606)	0	0	0	0	0	0	0	0	0	0	(606)	21
22	Employee Benefits & Payroll Taxes	(2,821)	0	0	0	0	0	0	0	0	0	0	(2,821)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(6,480)	(82,669)	0	0	0	0	0	0	0	0	0	(89,149)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,411)	(82,669)	0	0	0	0	0	0	0	0	0	(90,080)	29

STATE OF ILLINOIS
CANTERBURY MANOR NURSING CENTER
ID# 0027342
Report Period Beginning: 01/01/00
Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DETAIL FOR LINE 29 SCHEDULE VI	$		1
2				2
3	ELIMINATE EMPLOYER CONTRIBUTION TO IRA	(2,821)	22	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
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76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(2,821)		90

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER **#** 0027342 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	664	11,373	0	0	0	0	0	0	0	0	0	12,037	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28,557)	28,557	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	15,009	0	0	0	0	0	0	0	0	0	15,009	33
34	Rent-Facility & Grounds	0	(311,400)	0	0	0	0	0	0	0	0	0	(311,400)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(27,893)	(256,461)	0	0	0	0	0	0	0	0	0	(284,354)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(35,304)	(339,130)	0	0	0	0	0	0	0	0	0	(374,434)	45

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
LIST ATTACHED		SENIOR MANOR NURSING CENTER	SPARTA	Jamestown Mgmt Corp	Carbondale	Management
		FREEBURG CARE CENTER	FREEBURG			
		THREE SPRINGS LODGE	CHESTER			
		FAIR ACRES NURSING HOME	DUQUOIN			
		FAIRVIEW NURSING CENTER	DUQUOIN			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	MANAGEMENT FEES	$ 191,391	JAMESTOWN MANAGEMENT CORPORATION	10.00%	$ 108,722	$ (82,669)	1
2	V	33	REAL ESTATE TAXES		WATERLOO LAND TRUST		15,009	15,009	2
3	V	34	RENT	311,400	WATERLOO LAND TRUST			(311,400)	3
4	V	32	INTEREST EXPENSE		WATERLOO LAND TRUST		29,435	29,435	4
5	V	30	DEPRECIATION		WATERLOO LAND TRUST		11,373	11,373	5
6	V	32	INTEREST INCOME	878	WATERLOO LAND TRUST			(878)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 503,669			$ 164,539	$ * (339,130)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENT # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	***OWNER'S COMPENSATION HAS BEEN ELIMINATED PRIOR TO THE COST REPORT***							***	$ 0		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Jamestown Management Corp
Street Address: 1001 E Main Bldg 4a
City / State / Zip Code: Carbondale, IL 62901
Phone Number: ((618) 549-8331
Fax Number: ((618)549-0133

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	HOURS OF SERVICE	18,158		$ 7,064	$	3,450	$ 1,342	1
2	5	UTILITIES	HOURS OF SERVICE	18,158		2,367		3,450	450	2
3	17	ADMINISTRATIVE	HOURS OF SERVICE	10,440		317,177	317,177	1,984	60,276	3
4	19	LEGAL & ACCOUNTING	HOURS OF SERVICE	18,158		1,280		3,450	243	4
5	20	LICENSES & DUES	HOURS OF SERVICE	18,158		816		3,450	155	5
6	21	CLERICAL SALARIES	HOURS OF SERVICE	7,718		121,881	121,881	1,466	23,151	6
7	21	CLERICAL & GEN OFFICE EX	HOURS OF SERVICE	18,158		18,791		3,450	3,570	7
8	22	PAYROLL TAXES	HOURS OF SERVICE	18,158		46,167		3,450	8,772	8
9	24	SEMINARS	HOURS OF SERVICE	10,440		1,077		1,984	205	9
10	25	AUTO EXPENSES	HOURS OF SERVICE	10,440		8,770		1,984	1,667	10
11	26	GENERAL INSURANCE	HOURS OF SERVICE	18,158		5,657		3,450	1,075	11
12	30	DEPRECIATION	HOURS OF SERVICE	18,158		14,736		3,450	2,800	12
13	33	REAL ESTATE TAXES	HOURS OF SERVICE	18,158		0			0	13
14	34	RENT	HOURS OF SERVICE	18,158		26,400		3,450	5,016	14
15										15
16			**Excess salary of related individual has been							16
17			eliminated prior to cost report.							17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 572,183	$ 439,058		$ 108,722	25

Facility Name & ID Number CANTERBURY MANOR NURSING CENTI # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Canterbury Manor Nursing Ctr	x		2nd Mortgage	$1,593.00	06/95	$ 177,000	$		0.0900	$ 8,286	1
2	Canterbury Manor Nursing Ctr	x		1st Mortgage	$4,741.00	07-20-00	565,000	562,442		0.0900	21,149	2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$6,334.00		$ 742,000	$ 562,442			$ 29,435	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 742,000	$ 562,442			$ 29,435	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER **#** 0027342 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	15,009	2
3. Under or (over) accrual (line 2 minus line 1).	$	15,009	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	15,009	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1995	15,044	8
1996	14,487	9
1997	14,206	10
1998	13,968	11
1999	15,009	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 16,374 B. General Construction Type: Exterior Masonry Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Original bldg/addition	50,000	1970/75	$ 25,823	1
2	Additional land	22,597	1995	108,977	2
3	TOTALS	72,597		$ 134,800	3

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	60		1970	1970	$ 123,000	$	30	$ 2,050	$ 2,050	$ 123,000	4
5	14		1976	1976	80,226		25	3,209	3,209	77,283	5
6			1970	1970	49,513		25			49,513	6
7			1976	1976	866		10			866	7
8			1976	1976	10,413		15			10,413	8
	Improvement Type**										
9	VARIOUS/FULLY DEPRECIATED			1970	14,327		VARIOUS			14,327	9
10	REMODELING			1974	565		25			565	10
11	NURSES CALL SYSTEM			1976	7,457		15			7,457	11
12	NRUSES STATION			1976	30,851		20			30,851	12
13	SPRINKLER & SMOKE DETECTOR			1976	34,295		25	1,372	1,372	33,043	13
14	REMODELING			1977	6,714		15-20			6,714	14
15	LAND IMPROVEMENTS			1980	900		15			900	15
16	LAND & GUTTERING			1981	7,199		15			7,199	16
17	ROOF REPAIR & ACTIVITY ROOM			1986	30,422	2,028	15	2,028		29,406	17
18	PARKING LOT			1987	1,670		7			1,670	18
19	GAS LINE			1989	1,637	109	15	109		1,254	19
20	VARIOUS IMPROVEMENTS			1990	13,962	931	15	931		9,775	20
21	CABINETS & FLOORING			1994	2,461	164	15	164		1,067	21
22	VARIOUS IMPROVEMENTS			1994	21,632	1,442	15	1,442		9,373	22
23	ROOF REPAIR			1995	2,565	171	15	171		941	23
24	WATER HEATER			1995	3,000		15	200	200	1,100	24
25	FIRE ALARM			1995	7,207		15	480	480	2,640	25
26	TELEPHONE SYSTEM			1995	713		20	36	36	198	26
27	CARPETING			1996	2,423	346	7	346		1,557	27
28	RENOVATING ROOMS			1996	4,403	440	10	440		1,980	28
29	REPLACED WATER HEATER			1996	550		15	37	37	166	29
30	REPAIR SHOWER			1996	2,244	224	10	224		1,008	30
31	LANDSCAPING			1996	973	97	10	97		437	31
32	REPLACED WATER HEATER			1996	680		15	45	45	203	32
33	Labor/materials to remove existing and install new waterproof			1997	4,009	401	10	401		1,403	33
34	wallcovering and floor tile.										34
35	Labor/materials to remove and install new cabinets/ctrtops in nurses statio			1997	6,853	685	10	685		2,398	35
36	TOTAL (lines 4 thru 35)				$ 473,730	$ 7,038		$ 14,467	$ 7,429	$ 428,707	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	REPAIR PLUMBING			1997	4,010	267	15	267		935	9
10	REPAIR GROUNDWATER DRAIN			1997	790	53	15	53		185	10
11	PREP AND SEAL PARKING LOT			1997	1,145	229	5	229		802	11
12	SIGN			1997	531	106	5	106		371	12
13	OVERBED LIGHTING			1998	8,636	864	15	576	(288)	1,440	13
14	FLOORTILE AND CARPETING			1998	10,612	1,516	15	707	(809)	1,768	14
15	LANDSCAPING			1998	4,817	482	10	482		1,205	15
16	Labor/materials to remove entry way, rebuild walls, paint, &replace elec			1998	11,907	1,191	15	794	(397)	1,985	16
17	serv in DON, SocSer, breakroom. Move wall to expand kitchen. Created										17
18	storage area by relocating doors.										18
19											19
20	Trims, pictures, mirrors, & other permanent fixtures to			1998	3,025	49	5	605	556	1,513	20
21	refurbish the remodeled building.										21
22	PARKING LOT			1998	56,963		15	3,798	3,798	9,495	22
23	WATER SOFTNER			1998	1,400		10	140	140	350	23
24	FIRE SUPPRESION SYSTEM			1998	1,356		10	136	136	340	24
25	GAZEBO			1999	4,084		20	204	204	306	25
26	COURTYARD AWNINGS			1999	850		5	170	170	255	26
27	INSTALL 911 ALARM SYSTEM			1999	519	104	5	104		156	27
28	LANDSCAPING AND SIDEWALKS			1999	2,189	219	10	219		328	28
29	WINDOWS FOR FRONT OF BUILDING			1999	2,658	266	10	266		399	29
30	LANDSCAPING OF COURTYARD			1999	466	47	10	47		70	30
31	WALLPAPERING			1999	218	44	5	44		66	31
32	BUILDING ADDITION			1999	411,559		15	13,719	13,719	13,719	32
33	ADJUSTMENT TO 1999 DPA COST REPORT			1999	(173)						33
34	BUILDING ADDITION			2000	17,651		10	588	588	588	34
35	DOOR ALARM SYSTEM			2000	5,996	5,996		300	(5,696)	300	35
36	TOTAL (lines 4 thru 35)				$ 551,209	$ 11,433		$ 23,554	$ 12,121	$ 36,576	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Labor/materials to install new cabinets/countertops, relocate heating,			2000	1,346	1,346	10	67	(1,279)	67	9
10	electrical services, and lighting in the breakroom.										10
11	EXTENSION & MODEM JACK INSTALLED IN NEW OFFICE			2000	1,071	1,071	10	54	(1,017)	54	11
12	Labor/materials to remove existing wall and relocate wall to expand			2000	9,093	909	10	455	(454)	455	12
13	nurses station and install new cabinetry/countertops, lighting, and										13
14	electrical services.										14
15	INSTALL TILE FLOORING IN EAST WING			2000	6,858	686	15	229	(457)	229	15
16	CABINETS INSTALLED IN 6 MED ROOMS			2000	5,789	579	15	193	(386)	193	16
17	Labor and materials to remove existing cabinetry and sinks and			2000	2,845	285	15	95	(190)	95	17
18	install new cabinets/sinks, replace plumbing and electrical on east wing										18
19	ABSTRACT WATER FOUNTAIN IN COURTYARD			2000	1,155	165	5	116	(49)	116	19
20	FRUIT URN FOUNTAIN IN DRIVE			2000	945	135	5	95	(40)	95	20
21	LANDSCAPING			2000	1,519	152	10	76	(76)	76	21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 30,621	$ 5,328		$ 1,380	$ (3,948)	$ 1,380	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 97,369	$	$ 8,846	$ 8,846	VAR	$ 64,381	37
38	Current Year Purchases	31,870	15,003	2,592	(12,411)	VAR	2,592	38
39	Fully Depreciated Assets	117,510					117,510	39
40								40
41	TOTALS	$ 246,749	$ 15,003	$ 11,438	$ (3,565)		$ 184,483	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	JAMESTOWN ALLOCATION			$	$ 2,800	$ 2,800	$		$ 12,544	42
43										43
44										44
45										45
46	TOTALS			$	$ 2,800	$ 2,800	$		$ 12,544	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,437,109	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 41,602	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 53,639	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 12,037	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 663,690	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 235 Description: ladder 22; storage 114; lawn seeder 99
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

We only hire trained Aides.
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39/3 & 39/2	hrs	$	457	$ 25,172	$ 181	457	$ 25,353	1
2	Licensed Speech and Language Development Therapist	39/3	hrs		116	1,602		116	1,602	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39/3	hrs		458	25,503		458	25,503	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/2	# of prescrpts				7,738		7,738	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Oxygen, tubefeeding, medical supplies Other (specify): xray, labs	39/2 39/3				1,043	5,075		6,118	13
14	TOTAL			$	1,031	$ 53,320	$ 12,994	1,031	$ 66,314	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER **#** 0027342 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 22,520	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	332,209		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	16,168		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Income taxes	102,400		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 473,297	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	190,076		15
16	Equipment, at Historical Cost	171,759		16
17	Accumulated Depreciation (book methods)	(251,272)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Loan to Waterloo Land Trust	562,442		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 673,005	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,146,302	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 30,477	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	28,921		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,473		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 75,871	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 75,871	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,070,431	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,146,302	$	48

***(See instructions.)**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 962,605	1
2	Restatements (describe):		2
3	**Federal & State Income Taxes 1999**	(107,308)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 855,297	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	235,134	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(20,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 215,134	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,070,431	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,234,813	1
2	Discounts and Allowances for all Levels	19,377	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,254,190	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	90,045	6
7	Oxygen	2,896	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 92,941	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray	1,300	20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,300	23
	D. Non-Operating Revenue		
24	Contributions	10,093	24
25	Interest and Other Investment Income***	38,417	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 48,510	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,396,941	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	413,800	31
32	Health Care	827,972	32
33	General Administration	462,658	33
	B. Capital Expense		
34	Ownership	350,437	34
	C. Ancillary Expense		
35	Special Cost Centers	66,314	35
36	Provider Participation Fee	40,626	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,161,807	40
41	**Income before Income Taxes (line 30 minus line 40)****	235,134	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 235,134	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** no **If not, please attach a reconciliation. Federal income tax is n**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,912	2,040	$ 38,298	$ 18.77	1
2	Assistant Director of Nursing					2
3	Registered Nurses	940	1,201	21,321	17.75	3
4	Licensed Practical Nurses	15,359	16,337	229,782	14.07	4
5	Nurse Aides & Orderlies	40,641	42,920	394,403	9.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,428	1,540	17,297	11.23	8
9	Activity Director	3,515	3,691	34,625	9.38	9
10	Activity Assistants					10
11	Social Service Workers	1,965	2,076	27,333	13.17	11
12	Dietician					12
13	Food Service Supervisor	2,037	2,196	27,636	12.58	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,193	9,628	72,626	7.54	15
16	Dishwashers					16
17	Maintenance Workers	2,058	2,200	22,088	10.04	17
18	Housekeepers	6,667	6,902	52,304	7.58	18
19	Laundry	4,708	5,068	42,585	8.40	19
20	Administrator	1,984	2,080	54,173	26.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,942	1,972	19,002	9.64	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) WARD CLERK	861	922	6,606	7.16	33
34	TOTAL (lines 1 - 33)	95,210	100,773	$ 1,060,079 *	$ 10.52	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	113	$ 5,313	L1/C3	35
36	Medical Director				36
37	Medical Records Consultant		1,010	L10/C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant		600	L10/C3	39
40	Physical Therapy Consultant	64	3,367	L10A/C3	40
41	Occupational Therapy Consultant	36	2,180	L10A/C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	42	2,160	L11/C3	44
45	Social Service Consultant	42	2,160	L12/C3	45
46	Other(specify) DENTAL CONSULTANT		75	L10/C3	46
47	LAUNDRY CONSULTANT		30	L4/C3	47
48	Billing Cons 3680; Purchasing 1038		4,718	L19/C3	48
49	TOTAL (lines 35 - 48)	297	$ 21,613		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses	683	18,654	L10/C3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	683	$ 18,654		53

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
LINDA SIMMONS	Current administrator	0	$ 54,173
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 54,173

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
JAMESTOWN MGMT CORP	MANAGEMENT	$ 191,391
MIKRON	COMPUTER	1,020
ADP	PAYROLL	576
BARNETT & LEVINE	ACCOUNTING	698
M.E.S.	PURCHASING	1,038
NCS HEALTHCARE	BILLING	3,680
BENEFIT PLANNING CONS.	401k SERVICES	400
GILBERT, KIMMEL, HUFFMAN	LEGAL	1,027
PROSSER, & HEWSON LTD		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 199,830

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,608
Unemployment Compensation Insurance	9,406
FICA Taxes	81,096
Employee Health Insurance	11,855
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K EMPLOYER MATCHING FUNDS	3,831
LIFE INSURANCE	57
AWARDS, ATTENDANCE, PARTIES, ECT	17,081
VACCINES	1,529
JAMESTOWN ALLOCATION	8,772
TOTAL (agree to Schedule V, line 22, col.8)	$ 163,235

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,139
Health Care Worker Background Check	
(Indicate # of checks performed 31)	372
DON DUES	15
NAGNA	1,776
INHAA 75; CLIA 150; CORP FEES 303	528
SUBSCRIPTIONS	468
PUBLIC RELATIONS 2490; DIR ADV 563	3,053
JAMESTOWN ALLOCATION	155
Less: Public Relations Expense	(2,490)
Non-allowable advertising	( )
Yellow page advertising	(563)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,653

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	821
Seminar Expense	1,693
JAMESTOWN ALLOCATION	205
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,719

**See instructions.

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	PAINTING	1996	$ 2,443	3	$ 814	$ 814	$	$	$	$	$	$	$
2													
3													
4													
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15													
16													
17													
18													
19													
20	TOTALS		$ 2,443		$ 814	$ 814	$	$	$	$	$	$	$

Facility Name & ID Number CANTERBURY MANOR NURSING CENTER # 0027342 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? NO

(2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ N/A Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? no
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 40,626
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? yes Indicate the amount. $ 636

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? NONE
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report?
Attach invoices and a summary of services for all architect and appraisal fees.

CANTERBURY MANOR NURSING CENTER
RECLASSIFICATIONS ON DPA COST REPORT 12/31/00
PAGES 3 & 4 COLUMN 5

LINE #	ACCOUNT TITLE	DEBIT	CREDIT
2	FOOD PURCHASE	4165	
10	NURSING & MEDICAL RECORDS		4165
	RECLASSIFY FOOD SUPPLEMENTS		
21	CLERICAL & GEN OFFICE EXP	2001	
10	NURSING & MEDICAL RECORDS		2001
	RECLASSIFY OFFICE SUPPLIES		
10	NURSING & MEDICAL RECORD	980	
3	HOUSEKEEPING		980
	RECLASSIFY SOAP & SHAMPOO		
2	FOOD PURCHASE	1774	
11	ACTIVITIES		1774
	RECLASSIFY FOOD PURCHASED FOR ACTIVITY DEPT		
VARIOUS	VARIOUS LINE ITEMS	108722	
19	PROFESSIONAL SERVICES		108722
	RECLASSIFY JAMESTOWN ALLOCATION		
	SEE SCHEDULE VIII FOR BREAKDOWN		